AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

March 6, 2018

The Honorable R. Alexander Acosta
Secretary of Labor
U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue NW, Room N-5655
Washington, DC 20210

Re: Definition of Employer—Small Business Health Plans RIN 1210-AB85

Dear Secretary Acosta:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments on the U.S. Department of Labor (DOL) proposed rule regarding Association Health Plans (AHP) (RIN 1210-AB85).

The AMA supports efforts to maximize health plan choices for individuals and small businesses seeking coverage in the individual and small group markets. The AHPs defined by and outlined in the proposed rule, however, fall short of maintaining crucial state and federal patient and provider protections and would result in substandard health insurance coverage. We are also concerned about questions raised by the proposed rule regarding the preemption of state insurance laws and the potential for insolvent and fraudulent AHPs.

Health System Reform and AHPs

The AMA has long advocated for health insurance coverage for all Americans, patient freedom of choice, and physician freedom of practice. These policy positions are guided by the actions of the AMA House of Delegates, composed of representatives of more than 190 state and national specialty medical associations, and they form the basis for AMA consideration of reforms to our health care system. Health system reform is an ongoing quest for improvement, and we continue to support policy goals to expand coverage, improve the individual market for insurance, and provide premium subsidies that are inversely related to income to make high quality, affordable health care coverage accessible to all Americans. We recognize, however, that our current health care system is imperfect and there are a number of issues that need to be addressed. As such, we welcome proposals, consistent with AMA policy, to make coverage more affordable, provide greater choice, and increase the number of individuals with health insurance coverage.

The AMA strongly believes that the coverage gains of the past decade should be maintained. Central to this principle is ensuring meaningful coverage, assisting individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations, and ensuring the continuation of essential health benefit (EHB) categories and their associated protections against annual and lifetime limits and out-of-pocket expenses. Affordability is also critical, as is stabilizing and

strengthening the individual health insurance market, maintaining key insurance market reforms under current law, and expanding choice of health insurance coverage to best meet individual needs.

While the proposed rule expanding AHPs could potentially aid small businesses and individuals by enhancing consumer choice and making health insurance plans less expensive, the AMA is very concerned that, overall, DOL's proposal does not maintain key consumer protections and does not meet the AMA's key principles on health system reform as summarized above, and would result in substandard health insurance coverage.

Specifically, under the proposed rule AHPs would be able to offer health insurance that qualifies as large group coverage to all of its employer members. However, large group coverage does not have to comply with many of the consumer protections under current law. These protections include: providing 10 EHB categories—including maternity care, prescription drugs, and mental health and substance use disorder services—that current law requires of insurance sold to individuals and small businesses; prohibiting varying rates based on gender, age, occupation, and group size; having a single risk pool for all enrollees to set premium rates; and risk adjustments of claims. Importantly, key cost protections guaranteed under current law, i.e., the annual cap on out-of-pocket costs and the ban on annual and lifetime limits, are only applicable to services considered EHBs.

By operating under the Employment Retirement Income and Security Act of 1974 (ERISA), AHPs could not determine eligibility, premiums, or benefits based on health status. However, AHPs would be able to make benefit package decisions that could disproportionately impact individuals with pre-existing conditions, as well as cherry-pick healthier "working owners" and small businesses from the individual and small group marketplaces. While the proposed rule on its face might protect coverage of pre-existing conditions, in reality AHPs may not cover the actual services needed to treat pre-existing conditions.

Moreover, under the proposed rule, it appears that state patient and provider protection laws will not be consistent with and enforceable under the laws of the state in which the patient resides. DOL does propose that AHPs operate as a Multiple Employer Welfare Arrangements (MEWA), meaning that not all state insurance laws are preempted by ERISA. However, the AMA opposes the weakening of any state's laws or regulations involving: network adequacy and transparency; fair contracting and claims handling; prompt pay for physicians; regulation of unfair health insurance market products and activities; rating and underwriting rules; grievance and appeals procedures; and fraud.

We are also concerned that the proposed rule would weaken the already fragile insurance marketplaces and result in market segmentation, violating our principle that health system reform proposals should stabilize and strengthen health insurance markets. It is essential that health plans competing to enroll individuals and small groups operate on an even playing field in which all plans play by the same rules in order to prevent adverse selection. The proposed rule would create an uneven playing field between AHPs and the individual and small group markets that have to abide by requirements under the Affordable Care Act (ACA), especially with respect to EHBs and age rating. By enabling "working owners" to have access to AHP group coverage, the proposed rule has the potential to lead to healthy self-employed individuals enrolling in AHP coverage versus ACA marketplace coverage. Likewise, AHPs as envisioned in the proposed rule are expected to siphon off small businesses with healthier employees from the ACA small group market. Such adverse selections will likely increase costs for individuals in plans following ACA requirements.

Therefore, for the above reasons, the **AMA opposes the expansion of AHPs as defined by and outlined in the proposed rule**. We therefore urge DOL to withdraw the proposed rule and work with state insurance commissioners and health care stakeholders to seek a solution that would expand affordable insurance coverage options through AHPs without undermining state authority to regulate AHPs to protect patients, physicians and other health care professionals and institutions, and the health insurance marketplaces against such things as fraud and insurer insolvency. Our comments below offer some of the issues we believe warrant further consideration.

Federal Preemption of State Insurance Laws

Congress amended ERISA in 1983 to provide an exception to ERISA's preemption provisions for the regulation of MEWAs under state insurance laws. The AMA seeks clarification as to the preemption of AHPs as MEWAs. ERISA preemption is complex and can be highly confusing with the interaction of the deeming clause, savings clause, and MEWA exemptions from certain ERISA preemptions along with the different treatment between self-insured and fully insured plans.

While the AMA appreciates that not every instance can be described, any further guidance regarding what state insurance laws apply to AHPs and what state insurance laws are "inconsistent with ERISA" would be beneficial. These instructions would lessen confusion among states and help prevent fraudulent AHPs from forming because of confusion around what government entity has enforcement authority. Specifically, the AMA believes the following questions need to be addressed and clarified:

- whether states can outright prohibit the formation or operation of an AHP under the final rule;
- whether states can require AHPs to cover certain state mandated benefits;
- whether states can require individual and small group ACA-like consumer protections for AHPs;
- whether there is any impact on state solvency laws; and
- whether there is any difference in preemption between fully insured and self-insured AHPs.

Overall, we are concerned that the proposed rule will lead to AHPs incorporating in the lowest common denominator state with the fewest consumer and provider protections. AMA members, state medical societies, and other stakeholders have worked over many years with state legislatures, governors, and other stakeholders to enact these crucial protections. Allowing AHPs to circumvent these state laws will harm patients and physician practices.

Fraud and Insolvency Concerns

The AMA is very concerned that the proposed rule would lead to a greater potential for fraudulent AHPs and AHPs with insufficient capital sprouting up without sufficient state oversight. Insolvent and sham AHPs would negatively impact patients, physicians, and other providers by leaving them to cover the cost of services that should have been paid by the AHP. The result would be increased costs to patients and the health care system overall. Moreover, patients' health may be impacted as they would have limited access to care. As the proposed rule states: "AHPs have the potential to create significant efficiencies that could lower premiums across the board."[1] However, without proper oversight to account for insolvency and fraud, AHPs also have the potential to increase already high insurance premiums and overall health care costs, while threatening patients' health and financial security and the financial stability of physician practices and other providers.

[1] 83 Fed. Reg. 614, 628 (Jan. 5, 2018).

The following steps would help prevent potential insolvent and fraudulent AHPs:

- Require AHPs to receive a federal designation;
- Require AHPs to provide explicit notice to participants and beneficiaries;
- Provide clear statement on states' enforcement authority over AHPs; and
- Adequately fund DOL implementation and oversight activities.

Given the history of insolvency and concerns with fraud, AHPs should be required to receive a federal designation. Such designation can include basic contact information and description on how the AHP meets the commonality of interest test. Furthermore, AHPs should be required to attest to the truth and accuracy of the information provided for the designation and subject any signature to the penalty of perjury. This provision would provide DOL with the universe of AHPs that will operate under the final rule, which will greatly help oversight and coordination with state insurance commissioners.

The AMA believes that notice requirements are needed to ensure that employer members of associations and participants and beneficiaries of group health plans are adequately informed of their rights or responsibilities with respect to AHP coverage. The notice should be of an appropriate reading level and in a language appropriate to the patient population served. Importantly, such notice must include information on whom to contact at the state insurance department or DOL with complaints. Patient recourse is an important tool in preventing fraud and abuse. The vast majority of sham insurance plans are discovered through consumer complaints to government authorities.[2]

As described above, states' enforcement authority over AHPs should be clarified. An AHP framework where the barrier to entry is lower could enable criminals to establish and quickly expand scam AHPs across state lines. Fraudsters prey upon areas of regulatory ambiguity and may challenge such authority in courts to further delay enforcement, which allows more time to increase unpaid medical claims. At a minimum, DOL needs to fully cooperate and collaborate with state insurance commissioners to delineate where state authority ends and federal authority begins.

Finally, federal oversight over AHPs would need to be adequately funded. The AHP proposed rule would create a new federal bureaucracy that would result in significantly higher federal regulatory costs. In looking at previous AHP legislation, DOL testified that they had resources to review each ERISA health plan once every 300 years.[3] This level of oversight would not be adequate for AHPs. Without proper resources, AMA is concerned about DOL abilities to quickly detect and properly use its enforcement authorities to shut down insolvent and sham AHPs.

Request for Information

The AMA appreciates that the DOL is requesting information regarding the preemption of state laws for AHPs. The AMA believes that any preemption of state insurance laws presents an increased risk of fraud and insolvency, and would limit the effect of state oversight of AHPs.

The AMA supports the role of states in serving as the primary regulators of the business of health insurance and is frequently supportive of proposals that allow state flexibility in determining the most

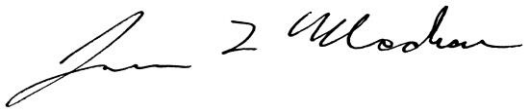
[2] GAO, *Private Health Insurance: Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage*, GAO-04-312 (2004), available at https://www.gao.gov/new.items/d04312.pdf.
[3] 145 Cong. Rec. H9006 (1999).

effective and comprehensive way to deliver care—provided that proposals maintain critical state and federal consumer protections; cover at least as many people; maintain or improve upon established levels of quality of care; ensure and maximize patient choice of physician and private health plan; and include reforms that eliminate denials for pre-existing conditions.

Additionally, the AMA would support selling of health insurance across state lines, including multi-state compacts, when patient and provider protection laws are consistent with and enforceable under the laws of the state in which the patient resides. As stated above, these protections include not weakening any state's laws or regulations involving: network adequacy and transparency; fair contracting and claims handling; prompt pay for physicians; regulation of unfair health insurance market products and activities; rating and underwriting rules; grievance and appeals procedures; and fraud. Furthermore, the AMA believes that patients purchasing an out-of-state policy should retain the right to bring a claim in a state court in the state in which the patient resides.

We appreciate the opportunity to provide our comments on the proposed rule. Should you have any questions, please contact Paul Westfall, Washington Counsel, Division of Legislative Counsel at paul.westfall@ama-assn.org or 202-789-7430.

Sincerely,



James L. Madara, MD